

Transcript

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And I'll introduce our guest tonight.

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I'm really excited about this one because I've been following with Doctor Chetty for a few months now since I first heard about him a few months ago when he did a really interesting talk on what he's been experiencing.

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So, Doctor, Shankara Chetty is a General practitioner with the natural science background.

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Genetics, Advanced biology, microbiology, and biochemistry.

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He has become recognized the world over for a successful management of COVID patients.

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His broad natural science background afforded him a unique perspective of the pandemic, convincing him that something was missing despite a wealth of knowledge around hospital presentations, pathology, and investigations, he saw that there was a distinct lack of information on initial presentation progression and pathogenesis now.

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Particularly, I've been interested in your 8th day observations, Dr.

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Cheesy, and I think oh, before we get started, if you wouldn't mind giving us a little brief about the not medical advice, that sort of thing.

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Good morning, good morning to everyone.

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I think good evening to everyone there in New Zealand where I think the majority of viewers.

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Yes, now what we present today.

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We're providing an understanding of a perspective of what's happening with COVID, and it's not meant to be medical advice to be taken without the consultation of your general.

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Practitioner COVID is a serious illness, and it shouldn't be taken lightly as much as we found ways to treat this and negate mortality and morbidity, I think your GP should be involved in any decisions you make.

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Thank you and I forgot to say you're coming in from South Africa.

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Yes, well that's in South Africa.

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Are you based?

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Uh, I live in a little town called Port Edward.

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It's a little boutique holiday destination, but I'm surrounded by a lot of settlements and so I have a very large clientele.

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But we live in what I'd call a rustic rural village.

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Awesome, well thank you and welcome again and I'm just wondering if we could start off if you could give us an overview of the clinical observations that you've made over the past 1820 months of treating over 7000 patients within your practice. So specially the 8th day observations that you that you've come across.

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OK, to put it into a nutshell, I endeavored to examine every patient that came into my practice.

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I didn't do telemedicine and things like that.

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I wanted to understand why people were going into hospital and in the first wave we knew that the breathlessness was what was driving this pandemic and causing all the mortality and morbidity.

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So, I wanted to interrogate that a little further.

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Before the pandemic got to South Africa, there was a lot of fear from my clientele about not being available, but I made sure I encourage them that I would be available, and they must come to me early so that I could understand the illness.

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Very early on, patient started presenting very early with symptoms as soon as they had a sore throat, they came to see me.

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And I educated every single one of them to present back if symptoms worsened, I wanted to understand from a clinical picture exactly what was going on with this illness and why people were actually ending up in hospital from the world around with before the pandemic hit South Africa.

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We knew that people were deteriorating.

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Relatively quickly we were hearing stories about people collapsing on the streets and things like that.

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And that didn't sound like a viral illness.

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It sounded something.

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Thing strange, we have a wealth of knowledge which we can always fall back on.

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And when we analyze such things, it's not about randomized trials but more about looking at the unusual cases to bring some understanding.

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Doctors usually discuss this kind of thing in the lounge at the end of the day, and that's what brought scientific discovery, not randomized charts.

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So, I wanted to understand.

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What was unique about this?

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The illness itself?

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And so, I ask patients that they come back if symptoms worsened very early on, I noticed a trend.

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I had a subset of patients that came back breathless.

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Not everyone. I think it was about 20 or 30% at the time. Those patients that came back breathless, strangely enough, presented exactly a week.

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After the onset of their initial symptom, I went back.

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I checked my records, I started interrogating patients about the exact day that they started to feel unwell, and I noticed that the breathlessness always started exactly a week after the initial symptom or the initial feeling of being unwell.

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And that seemed very strange as well.

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With these patients that presented back when in, when interrogated about the progress the day before they started to feel breathless, they were perfectly fine.

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They had thought that they had recovered, and of course that tidying with all the narrations of people that had demised there.

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It's always narrated that from family members that they thought the individual was getting better and suddenly took a turn for the worse.

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So, it seemed like there was a turn on the 8th.

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Something seemed to be changing on that day. Now would that change I I knew from the start I had to get myself A2 box of drugs that might work in this.

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Now the first seven days of illness seemed to be an ordinary viral flu.

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There was absolutely nothing unusual about those seven days.

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Some had sore throats that resolved within the day.

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Others got Co infections with bacteria, bacteria and needed antibiotics.

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And I think we all respond to viral infections slightly differently.

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Some of us are more resilient than others.

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You hear people saying it always goes into my chest, and so I, I think we knew how to treat that first phase.

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But on the eighth day I needed to do something different, something had changed and steroids.

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We knew that this was a steroid response awareness.

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So that formed a timeline and a point in time where to initiate steroids.

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Without being too aggressive but would also not.

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Not dowsing your immune response, so it seemed like people had recovered and something else that started.

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Now I started with steroids.

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On the first few patients they showed signs of improvement with recoveries.

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But I had.

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It in the back of my mind that I was dealing with an allergic process.

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From before the pandemic came from looking at the presentations around the world and that kind of thing.

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I had a suspicion that we're dealing with some kind of immune response here on the eighth day, while the 8th day came to be once, I started to examine these patients, it took two or three days for patients to start to show Rick signs of recovery with the steroid itself.

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So, I decided that.

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I would have to attempt a what I'd call a therapeutic trial of different medications.

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The speed to recovery using those different medications will dictate the underlying mechanism, and so by I think the 5th patient.

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I had a lady that was in her 40s that was diabetic and hypertensive who came in on the eighth day who was perfectly fine the day before and she had a saturation of.

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80% one of the more critically ill patients at sea.

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And so, I decided, well, I, I was well aware of the time to recovery with steroids.

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It took a few days for them to improve, so to that steroid I added the kiddies dose of promethazine, 'cause I was suspicious we're dealing with a hypersensitivity reaction.

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Yeah, and with that kiddies dose of promethazine I followed up on while every one of my patients from the 8th day I they got uh.

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Phone call every day to ensure good clinical recovery.

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And amazingly, by the next day, she was perfectly fine.

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Her saturations were fine, everything he had resolved with the kiddies dose of antihistamine.

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But I had just given her a single day of treatment, so I I asked my staff to contact her and remind her that if the breathlessness resurfaces, she needs to come back.

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I suspected that it would seem that we had just given.

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A day of antihistamine and by the following day, the breathlessness did show up, and so she came back, and we treated her, and she resolved again very quick.

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And that drew my attention to this being a hypersensitivity reaction triggered by something on the 8th.

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Day now when you look at viruses, viruses tend to have a finite replication cycle.

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Measles only lasts that long.

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Chicken pox as well.

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It has an evolution to it.

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We can track the illness and so I decided I needed to track the staleness through.

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And to figure out exactly what was triggering this process on the age.

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This day now the first seven days seem to be a viral infection, and by the 6th or 7th day majority of patients got their appetites back, which is usually a sign of recovery and your immunity kicking in.

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But everything took a turn on the eighth day with some patients now understanding that it was hypersensitivity.

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Hypersensitivity causes the release of certain chemical mediators.

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Like a bee sting and you'd have a varied degree of allergy to such an allergen, so some would have very mild symptoms, some moderate and some very severe, bordering on anaphylaxis, and would deteriorate very rapidly now when you treat patients on the eighth day, you can't wait to see how severe they actually are.

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They could deteriorate too quickly and this is a process if not caught early will cascade out of control very quickly, like a bee sting if I'm.

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Treated so every patient started or was started on aggressive treatment on that eighth day.

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We looked for quick clinical improvement and the clinical improvement.

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Determined the dosages and the weaning of certain medications now.

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The mediators that get released of fairly well known to almost every doctor.

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On the planet when you have an allergic reaction, you have the release of histamine.

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You have the release of leukotrienes prostaglandins and platelet activating factor.

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Now those four mediators need to be addressed.

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So the protocol that I started when I realized that this was the Type 1 hypersensitivity included antihistamines, Montelukast for the leukotrienes, and aspirin to prevent any clotting issues.

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I did look at Ginkgo biloba.

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Ginkgo biloba is a supplement that actually is a platelet activating factor.

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And so it's the only one that I could find that would work.

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Targeted Lee at platelet activating factor.

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So I started that kind of regimen as well.

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You've got to stop the process.

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This is just mopping mediators and to stop the process, steroids become vitally important, so you've gotta tap.

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That's opened and is spilling out.

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These poisonous mediators and the longer you leave it, the more damage it will do.

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The dose of steroid is vitally important in such conditions to stop the reaction itself.

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And that is how this protocol has evolved from the 8th day.

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If the patient worsens, they are having a severe allergic reaction and you got to be aggressive and timeless in catching that reaction and treating it the dose of steroid would be determined by the severity of the reaction and the severity of the reaction.

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Can be gauged by the speed of recovery.

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So I give a patient dose of steroid and I expect within four to six hours to see improvement.

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If not, I repeat that those until I get improvement.

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There's been a lot of controversy about the dose of steroid.

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I think that we need to understand what we're trying to treat so that we use the appropriate medication.

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The whole world has been chasing COVID pneumonia.

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This is not a covert pneumonia.

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Pneumonia is a progressive illness and you can see the patient deteriorate day by day until they develop pneumonia and become breathless.

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I've never had a patient that was perfectly fine and suddenly woke up one day tired and by the evening was breathless with the pneumonia.

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So this is actually a hypersensitivity allergen induced pulmonary pneumonitis, not to pneumonia.

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So it's an allergic reaction occurring deep in the lungs.

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It does affect the vascular system and the rest, but it is typically an allergic reaction occurring in the lung.

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And that's the reason for the speed of evolution.

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Anaphylaxis can occur very quick.

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Now if you compare these two conditions, COVID pneumonia and pulmonary hypersensitivity pneumonitis on X ray and high definition CT with the ground glass appearance that we've been seeing, both are identical.

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They cannot be told apart by X ray or CT, so I think we've been misdiagnosing

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COVID pneumonia as COVID pneumonia.

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We're dealing with the hypersensitivity pneumonitis now in COVID pneumonia.

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We're dealing with an infection in that condition and so steroids need to be used with great caution 'cause you're dealing with the virus and you don't want to hamper any immune response.

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However, with the hypersensitivity pneumonitis and post date day, where it seems like the virus has passed and your immune response has already had sufficient time to curtail that reaction, now you're trying to stop an allergic process, and the dose of steroid is vitally important.

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You have to use enough steroid.

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To suppress the reaction. So when you tell a doctor to use 50 milligrams of Prednisone, which is 10/5 milligram tablets, they feel that that is the maximum I've had to use. 100 milligrams, sometimes three times a day, to get a handle on the reaction, so you cannot limit the amount of water you'll use to put out.

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Fire, you'll never get a handle on things, and so you the quicker and more the quick, quicker this speed and aggression with which you start.

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That steroid will determine the length of treatment.

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The slower you initiate treatment, the longer you're going to have that patient on a steroid, whereas if you quick and aggressive once they've controlled, you can start to wean them off.

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And so I think the perspective took precedent rather than any medical intervention.

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To understand that we're dealing with the biphasic illness that is nonlinear, the first and second phase have no correlation between each.

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The second phase can be mild, moderate or severe, and I think the distinction of severity should start on the eighth day rather than from the 1st.

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Uh, majority of patients do not have this reaction, and I'm not at risk of having a hypersensitivity.

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All the mortality and morbidity in this.

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Pandemic resides in that part of the process, so the second phase is responsible for all the mortality and morbidity.

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So to put it into context, viruses like a bee.

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And The thing is, the allergic reaction.

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So we as a planet have been busy counting bees and chasing bees and trying to kill bees.

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But we haven't addressed Sting and the patients that have been stung by this, I advised to go home and isolate and wait till they.

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Deteriorates unfortunately.

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By that time you have multisystem disorder.

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You've damaged your body in many ways, and of course presenting to our hospital is a bit late.

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That negates the speed and aggression without having to address this, and of course a majority of doctors in the hospital, unaware that you've been stuck with the B, so the appropriate method of treating it is not available.

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Yeah, and so the perspective is vitally important rather than any treatment protocol in the second wave there was a little bit more that came to the picture in the first wave.

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With this modality of treatment, we had no long COVID because.

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You stopped the.

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Reaction and we also had no complications from COVID.

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I went through about 6 to 700 patients in the 1st grade when we had complete recoveries, very timelessly, and so in the second wave approaching the 2nd wave, I started to see patients who are suffering with long covid

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To me and I took the opportunity there to try and understand what was going on.

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I'm of the opinion that long COVID is a moderate hypersensitivity reaction that's gone untreated, and if you got stung with the bee and you developed a rash all over your body and you never treated it would take months to a year to actually get over it.

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Get over that and that's long.

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Prove it for you.

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So what we're dealing with is mild, moderate and severe allergic reactions triggered on the eighth day in a subset of population that are prone to this genetically predis

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Opposed the genetic predisposition was plain to see in the start you found in families that were infected.

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Father and sons had severe illness and mother and daughters never had anything wrong or the opposite, but it seemed to be affecting males more, so there was a genetic definite genetic predisposition.

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I didn't see any of that.

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Mobility is really play a role in.

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It I've had diabetic, hypertensive, elderly obese patients that recovered even after having the reaction.

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Uh, quite timelessly, and I've had young patients with absolutely no comma comorbidities get critically ill.

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Yeah, so the the predisposition, the biggest risk factor is where the you allergic or not.

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So I think Abby doesn't care whether you're hypertensive or diabetic to kill you all that all that's necessary is that you're allergic to its sting.

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Now, in the first wave, with the realization that I'm dealing with hypersensitivity here and a type one kind of hypersensitivity that posed some questions and brought some bad omens for the 2nd wave.

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When a person is allergic to something, the first exposure to an allergen never brings the reaction.

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'cause you don't have the inappropriate antibodies developed yet.

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But once you expose to that allergen, you become sensitized and so you develop the inappropriate.

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Immunoglobulin E antibodies, and so when re exposed, you react now in the 1st way, we found that people over 55 were more prone to mortality and mobility from this illness.

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And I had seen that the people where the the the talk was that it was related to comorbidities and age.

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However, I didn't see that the risks seem to be unrelated to those kind of comorbidities, so I was under the impression that people over 55 were likely to be exposed.

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To something very similar to this Corona virus before in their lives, and that developed the necessary Ige.

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To have a response to it when now re exposed in the first wave and that's the reason they were having over 50 fives.

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More affected, however, are people below 55 in the first wave. That would be their first bee sting and that would sensitize them, and so I expected that in the second wave we were going to see a far younger subset.

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Right?

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With patients

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Having mortality and morbidity and that occurred around the globe, it was independent of variant.

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It was independent of Co mobility in the 2nd way we saw younger people die and unfortunately, if we realized this early on, we could have prevented a lot of those younger deaths.

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Uh, when I started seeing long COVID I started to try and fine tune what I was doing.

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I had to try and prove that on the eighth day we were seeing a sudden change.

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Now the markers that would lend credence to my theory where either proving the release of histamine.

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On that day, Tryptase, which is another marker on that day for showing immunoglobulin E levels rising.

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Now Tryptase an immunoglobulin E are a little slow to show up, so there's no point me showing an elevated mark on the 10th day when I'm trying to prove something occurring.

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On the 8th.

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Histamine and requires the collection of a 24 hour urine sample and of course, while I'm collecting that sample, I need to defer treatment and that wasn't an ethical thing to do, especially seeing that this could spiral out of control very quickly.

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So the proof of this became a little difficult, but however with long COVID cases they've been exposed to an allergen for a period of time and had enough time to develop these markers.

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So when I started getting long COVID cases coming to me for assistance.

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Coming to me for assistance, I started to do immunoglobulin essays on there and I found that in every single one of them it was elevated, which shown that they were having a long term allergic reaction.

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A muscle activation syndrome which is common in long term allergy and I use the same modality.

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You treat the.

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Someone that came to me with a rash for six months.

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I'd used the same.

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I put them on a short course of Prednisone to suppress it and use the antihistamines and Montelukast on the rest.

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A little bit of symptomatic treatment and I had all my long COVID patients show immediate signs of recovery are almost 80% recovered within the first week of treatment. It was.

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Very much the same with the acuity illness.

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So I understood clearly there that we're dealing with the hypersensitivity kind of reaction in the second wave.

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We had the notorious South African there yet.

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So I looked closely at that.

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I needed to understand the differences rather than the similarities and understand what those differences, how they changed the clinical picture I was seeing, and so I could draw some inference as to what the virus was doing.

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The South African variants, the mutation that caused the South African variant only caused a change.

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In the spike protein, the spike protein had changed by 40 to 60 amino acid base pairs, so a little change in the spike protein.

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Everything else on that South African variant was identical to the wild type.

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So the only thing that changed was the spike.

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Now in the second wave at the clinical, while we were well aware that we were dealing with a far more contagious period, her family members were being infected far more quickly than in the first wave.

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That contagiousness can be attributable to spike protein, greater affinity for your.

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Post Spike protein, after all, is the way the virus attaches to the host.

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And it had been on my radar for a long while.

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Seeing that spike, we've been told about coronavirus infected human beings.

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So the thing that would make a bad corona virus jumped species would be it's spike protein.

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And of course, if you're exposed to a new environment, they knew the newness of the environment would trigger allergic processes in your body, 'cause you haven't been exposed to it before.

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And so I thought that spike protein was what's?

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New on this.

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Virus and it would be the likely culprit.

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To trigger this allergic process on the eighth day.

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So in the in the second wave, we found that we had a more contagious variant which tide into spike.

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We had far more gastrointestinal symptoms which turned into spike protein.

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Again, a propensity for an affinity for ACE receptors in the gut, and of course on the eighth day we had far more allergic, severe allergic reactions, and so it drew my attention to the fact that.

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Spike protein.

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Was the allergen that was triggering this allergic process and so in the 2nd way we had to use a higher dose of steroid to suppress it.

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I think the dose of steroid is dictated by the variant because it's spike protein and the spike protein determines the allergenicity of the.

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And so different variants, different severities of allergic reactions, different mortality and morbidity.

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So the notorious South African variant was simply because of its ability to trigger a far more severe reaction on the eighth day, and if untreated, result in all that mortality and morbidity.

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So Spike protein took.

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Center stage as the pathogen of COVID illness.

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So what we're dealing with in this pandemic is not really a viral illness.

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The virus is not the primary pathogen of COVID illness.

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The virus gives you a short flu, which is transient.

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The primary pathogen of COVID illness spike protein spike protein is causing pathology that is responsible for all the mortality and mobility that we see.

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Coronavirus is just a vector.

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That puts the spike protein into your body itself.

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In the second wave.

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One other point I'd like to make in the second wave with all the gastrointestinal symptoms we've seen, I was under the impression that would that that was an allergic reaction triggered in your gut rather than anything else like it was triggered in your lungs.

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And so in the second wave, the presentation on the eighth day changed.

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People had a re emergence of the gastrointestinal symptoms.

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The diarrhea had come back.

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The heartburn had come back and of course two days later the breathlessness said you.

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So I think the target organ had changed a little bit, but the process was the same the 8th day still remained for worsening of symptoms, and of course the the treatment modality remained pretty much the same.

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In gut allergy, you would want to use an antihistamine that works on the gut.

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So the age 2 antihistamines, their blockers became more important. The Cimetidine's and Grenadines and former Deans and all other measure of treating these gut symptoms seem to have failed, but the cimetidine seemed to do the best, and so it again therapeutically therapeutic trial proved that.

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We were dealing with an allergic reaction in the gut itself.

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I think that what we need to understand is that in doctors have been doing therapeutic trials for many years.

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Every time a patient comes to see me with an illness, it's a therapeutic trial.

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And if she recovers the therapeutic trial worked, we are all individuals and we're all different.

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And so every time I medicate someone, I'm hoping that they would get better.

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Nothing is written in stone, and so it's a therapeutic trial speed to recovery always will determine the efficacy of that trial.

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Now, if I had to compare speed to recovery, has always been my preoccupation, because it determines the mechanism that underlies the condition itself, and we can.

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We can prove our our theory by speed to recovery.

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Now I have a doctor here in South Africa who use the protocol of the World Health Organization and the others that he could find available to him in the 1st.

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And 2nd wave.

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He's an intensivist, but treats patients on an outpatient basis.

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Those that are critically ill and in the third wave he came across my work, he was actually asked to look at my work.

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'cause I was making certain claims.

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And he contacted me and I educated him about it.

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Well, he contacted me 'cause he saw the benefit very quickly and within the first four patients he realized he was onto something and so I educated him about the perspective.

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Remember, we're talking perspective, not protocol.

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It's interchangeable with a lot of medications around the world, you understand.

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What you're treating then it becomes easy to choose from a wide diversity of tools in your hand and how to do this.

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So he contacted me.

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I educated him about what I'm doing and how we should look at this illness, and so it's been three months and so we decided to have a relook at where we've come in the 1st and 2nd wave he had a lot of deaths.

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He had a staff member demise.

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He had one of his interns demised in his.

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Uh, so I in the third wave he was very interested in looking at the way I was doing things 'cause I haven't had any debt and I promised him that I would try and negate the death in his practice. In the third wave he he had been through 1000 page.

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When we decided to re look at statistics in the 1st and 2nd wave, he had one or two deaths for every 10 patients that he saw.

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In the third wave, he had now gotten through 1000 patients without death.

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Simply by changing perspective, but of course that might be God's hand. And of course a milder variant at a different time. So speak to recovery again would determine how we do this.

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So I asked him to look at speech recovery. We considered a patient with the 70% saturation in the using the different modalities of treatment and how quickly they would actually recover the hypoxia being the critical marker or the recovery from hypoxia and in the 1st and 2nd wave.

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He had used rim disappear at tocilizumab dexamethasone anticoagulation.

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And what he found in the 1st and 2nd wave was that a patient with 70% would take at least three days to improve to 75%.

00:28:52

A lot of them moved in the other direction, some required ventilation and some demised.

00:28:58

Right?

00:28:58

In the third wave, using my modality of treatment, he found that, uh, similar.

00:29:04

Feel patient with a 70% saturation. Put onto my treatment.

00:29:08

Women would have their saturations improved to 85% within 4 hours, so there was no comparison within a day.

00:29:18

Within a day they were well into the 90% saturations and that's the reason I managed to negate the need for oxygen.

00:29:25

There was a tiniest improvement in the hypoxia, and so there was no need to have that patient put onto oxygen unnecessarily.

00:29:33

He wrote me a humorous little WhatsApp the other day to say in the first wave he chased trimmed a severe and he ran out.

00:29:42

Oxygen, sorry in the second wave rim disappear and in planning for the third wave he bought 100,000 grams worth of oxygen and £100,000 worth of frame disappear to make sure he was prepared.

00:29:52

And then he met me and he's got 100,000 grams of both lying in the.

00:29:56

Corner of his practice values.

00:29:58

Unfortunately, he had also set up a vaccination.

00:30:02

Time and now he wrote to me saying that he is 90 - 90 degree Pfizer.

00:30:07

Fridge seems to need to be turned off.

00:30:09

It's costing him too much in electricity and he should have listened to me in the 1st place about going down that road with vaccinations as well.

00:30:16

So yeah, the protocol is simple.

00:30:18

It's simple for doctors.

00:30:20

It's a simple perspective.

00:30:22

Uh, I have a very different view of this compared to people around the world.

00:30:27

I think the mortality and morbidity was wholly unnecessary.

00:30:31

I think that the public health interventions were absolutely nonsensical.

00:30:37

The deferment of early treatment is the reason for all the mortality and mobility, nothing else, and I think by deferring early treatment we have.

00:30:48

We have actually deferred the understanding of what truly is going on in this pandemic.

00:30:55

This is just.

00:30:56

It's a pleasure way.

00:30:57

The people in the comments are saying, you know your illusion.

00:31:00

They're really grateful for for what you're sharing with us here and and here in New Zealand.

00:31:05

You know our doctors and the mainstream are not talking about any of this sort of stuff.

00:31:11

Is there any advice that you would have for them other than just to listen to what?

00:31:15

I've just seen for the last half an hour.

00:31:18

Uh, I think.

00:31:20

I think the fear mongering from the start has caused a lot of the problems amongst the general population amongst doctors.

00:31:29

Uh, I I'm a.

00:31:31

Spiritual person that has a lot of faith in God.

00:31:34

And so I took this risk.

00:31:35

It's my work to keep people safe and so I had to take the risk, but after doing so I realized that there was no reason to fear.

00:31:46

Yes, I think a lot of doctors around the world that have had to watch their patients demise and that brings a lot of fear, trepidation, but this is simple.

00:31:50

Right?

00:31:55

If you could, even if you could just give your patient an antihistamine.

00:31:59

Promethazine was my choice because it's a first generation antihistamine and it's one that's been in our emergency medication toolbox for many years, and it has the quickest speed to recovery in that situation.

00:32:13

Give a patient one tablet.

00:32:15

And watch them recover and it will give you the confidence to do this.

00:32:19

Uh, I think the fear is has has changed the way we're dealing with this as a medical fraternity.

00:32:26

So to the doctors out there I think try, don't be afraid to try.

00:32:30

The modality is relatively simple.

00:32:33

All you gotta have at the back of your head is that uh, patients been stung with the B.

00:32:37

I've had many patients over the years.

00:32:38

Come in.

00:32:38

With anaphylaxis I'm

00:32:40

Maria de I mean many doctors around the world would have had that happen.

00:32:44

Yes, it's a scary situation.

00:32:45

We keep the patient in our consulting room 2.

00:32:48

We've turned that around and they've showing signs of improvement before we can release them to go home and continue the medication.

00:32:55

So that's all we need to do.

00:32:57

All we need to do is realize that on the eighth day we're having a severe hypersensitivity trigger and it needs to be addressed and be quick and aggressive.

00:33:05

I've treated hundreds of patients around the globe using Tele medicine, and I've had the same success with them as well, so I think we need not fear as far as the preventative measures.

00:33:17

There there's been a lot of confusion early on about the transmission of this virus.

00:33:21

We were told that it lives for 10 days on this surface and 20 days on that, and people were sanitizing their super marketing and the rest, and I thought that was absolutely nonsensical.

00:33:31

We got a huge body of knowledge that we've gained over all these years.

00:33:35

Why don't we look at that?

00:33:37

And so I don't believe very, very easily what I'm told, especially when there's an agenda out there.

00:33:45

And so I set up a tent outside my home in my parking.

00:33:48

Not my practice in my home are in the same premises and so I set up a tent.

00:33:53

I knew that ventilation and sunlight with the two most important things to shield me.

00:33:58

I knew that I had to wear a mask in a shield, but keep my hands away from my face.

00:34:03

I've never worn full PPE.

00:34:06

The mosque and my.

00:34:07

Shield was all that I required.

00:34:09

In fact, after the first wave I.

00:34:10

Threw away my shield.

00:34:12

It just became too much to do.

00:34:14

I had to triage my patience 'cause I made sure that I would be available to those that were not covert suspects.

00:34:20

So I set up a screening gestation at my front.

00:34:23

Wait, I separated COVID patients from COVID suspects and those that were neither kovid.

00:34:28

No suspects were allowed into my practice, so I had three different waiting areas.

00:34:33

I had someone to screen and separate those patients out.

00:34:36

In fact, in my practice, you know it's difficult to get people to keep their hands to themselves and that's the biggest way that this spreads.

00:34:42

So I put.

00:34:43

2 double red stripes on my floor until patients just stay between those stripes and somehow when you have to walk between stripes you keep your hands to your.

00:34:50

Stuff, and so that kept people understanding that look you gotta just keep an eye on yourself.

00:34:55

So I think there's little things that we can do to actually educate the public and make them understand what we're going through.

00:35:01

I used white coat so whenever I walked into my tent or put a white coat on and where whenever I walked out I carefully took it out that was washed at the end.

00:35:10

Of the day, I isolated myself from my family and the public for four.

00:35:14

Once all I did was see patients and go back into isolation, I needed to figure out what was going on, and then I think fate has a way of forcing us to lose our fear in that four months I had no debts. I had remarkable recoveries. I had patients who presented with 50% saturations recover.

00:35:33

And so, so there was absolutely no reason for me to be afraid, and I've seen far more severe illnesses that I've had patients demise from.

00:35:42

And here I was, winning and one fateful day, I came home, and I was talking to my son in the garden, socially distanced with the mask on.

00:35:50

And I stepped back and tripped over my dog and cracked my ankle and drove back to my flat.

00:35:56

But the next day it had swollen terribly, and so I managed to get back to my practice and I was busy getting my gardener to set up the room at the back of my home so that I could stay at home.

00:36:05

I couldn't drive anymore and then my son came to me and he said, dad, you know how to fix this illness but I just.

00:36:11

Whether you want to stay in the backroom?

00:36:13

And so I moved back home.

00:36:15

And I've been at home ever since.

00:36:16

I'm still seeing covered on a daily basis.

00:36:18

The fear is gone and I'm not sure whether I've had it.

00:36:22

But if I have, I'm sure I have natural immunity to it, so there's no reason for me to check.

00:36:26

I never once checked to see whether I've developed immunity from the flu itself and if we can buy early treatment.

00:36:33

Turn this into an endemic.

00:36:35

Flu then I don't see why we.

00:36:38

All afraid of it.

00:36:40

That that's that's amazing.

00:36:42

Thank you so much for that story.

00:36:44

That's really inspiring.

00:36:46

I'm wondering if we can switch track now and talk a little bit more about the spike protein and how you view that, and amongst us, all its pathogenesis.

00:37:00

Their long term exposure to the spike.

00:37:02

What are the risks of that sort of thing?

00:37:03

And then we'll move into the vaccine after that.

00:37:07

OK, look at.

00:37:09

I don't want to stir controversy and get involved in conspiracy, but there's certain logic and certain facts that dictates that a picture fits.

00:37:20

It's how I discovered hypersensitivity.

00:37:22

It was the only pathology that fitted on the eighth day, and so I think.

00:37:28

Good sense should prevail.

00:37:30

Looking at all the facts around us.

00:37:32

Now what I've discovered.

00:37:34

Is that spike protein is analogy?

00:37:37

It is the cause of all the mortality and morbidity.

00:37:41

So the focus for from my perspective has always been on spike protein.

00:37:45

And so I've been trying to push research to say stop looking at the virus start understanding spike protein that is the the the the.

00:37:54

Pathogen here and the understanding of spike protein will bring better understanding of the illness, it's progression.

00:38:00

It will also allow us to fine tune the way we treat this.

00:38:04

Yes, we've managed to curb the mortality and mobility, but we can do more to curb the suffering.

00:38:10

And so I I pushed researchers that were in contact with me to keep looking at the spike protein and understand what's going on here now.

00:38:19

Just to give you an understanding of why I needed to research spike protein more closely, let's take penicillin.

00:38:29

Penicillins and antibiotic.

00:38:31

Now it's antibiotic potential is what we'd call it's biologic effect.

00:38:37

That's what penicillin does.

00:38:38

It has a biologic effect of being an antibiotic killing bacteria in your body.

00:38:43

Now that biologic effect of penicillin is dependent on you taking the full course.

00:38:48

Now, if I had to give the entire planet a single dose of penicillin, it would not have that biologic effect of being an antibiotic.

00:38:58

It's just a single dose.

00:39:00

However, there's a group of people on this planet that are allergic to penicillin, and if I restrict treatment.

00:39:08

Of that allergic reaction that are triggered, I'll get mortality and morbidity from penicillin even in a single dose.

00:39:14

So that's what I was saying.

00:39:16

I was seeing the Allergenicity and I was seeing the mortality and morbidity from that allergenicity, but I needed to understand the fully thing.

00:39:25

'cause simply with the vaccines they get your body to produce by protein and that would be a.

00:39:33

Full dose.

00:39:34

And so I needed to understand what spike protein was doing in the body so that I could understand where we where we go from here.

00:39:41

Now looking at Spike protein.

00:39:43

Spike Protein is a very contrived toxin.

00:39:47

We know it's toxic to the human body, it's a pathogen.

00:39:50

It causes alegend allergy as a start.

00:39:54

Allergy is always what would show up first with anything allergies.

00:39:58

The first to show up those that are not allergic will be prone to the other biologic effects of this, so if you're not allowed allergic to penicillin, you can use it.

00:40:07

Is an antibiotic, so I needed to understand exactly what was happening with long term exposure to spike protein or what spike proteins struct.

00:40:17

Sure would what the propensity for injury would be from its structure itself.

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Now, from looking at the structure of spike protein, we well aware that it causes endothelial inflammation, which is inflammation of the lining of your vessels.

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We know that it causes myocarditis.

00:40:36

We've seen that in young kids.

00:40:38

Being vaccinated and we've seen that in some cases of COVID illness.

00:40:42

Those two effects of spike protein will cause thrombosis clotting.

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That side effect or that effect of spike protein would cause people with predisposed vessel injuries, like your diabetics and hypertensives, and those with high cholesterol values to be more prone to being injured by the Spike Pro.

00:41:05

And so I was expecting to see more heart attacks, more strokes, more DVTs, more pulmonary emboli in that subset of patients.

00:41:15

I was also expecting to see myocarditis but myocarditis across the entire range of age group.

00:41:23

Then it was discovered that that spike protein also has certain parts of it that have great similare.

00:41:32

To other pathogenic proteins.

00:41:35

Now when you look at those pathogenic proteins and the similarities spike protein has a lot of similarity to pathogenic HIV related proteins and those HIV related proteins or what caused the immunosuppression related to HIV illness.

00:41:51

And the aid syndrome that we see.

00:41:53

Uh, so I was expecting that spike protein would cause immunosuppression.

00:41:59

And this kind of immunosuppression would cause a re emergence of latent infections.

00:42:05

It would cause a re emergence of certain cancers that were in remission.

00:42:11

And so I was expecting those to occur with the long term exposure.

00:42:16

Then we found that spike protein had similarity to other pathogenic proteins called prions.

00:42:24

Now prions are proteins that have been implicated in Alzheimer's and dementia, and certain neurologic.

00:42:33

That those kind of illnesses are related to our called prion disease.

00:42:38

And seeing that we were dealing with a protein that had affinity or similarity to those kind of prions, I was expecting to see neuropathies neurologic manifestations of exposure to spike and of course.

00:42:53

Worsening in those patients who had dementia and Alzheimer's when they're exposed to spike.

00:43:00

Then Spike protein is also a membrane based protein.

00:43:05

It's incorporated into the viral surface.

00:43:08

And so I expected that spike protein, if made in your body, would be incorporated into the membranes of yourselves dependent on what servers making spike protein that incorporation into the membrane would cause your immune system to recognize the spike protein as foreign.

00:43:27

And so it would trigger a host of autoimmune responses depending on the tissue that was expressing the spike protein.

00:43:34

So this is the entire ambit of what I expected spike protein to actually do.

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Now, from examining long COVID cases, we see that those are exactly the systems that are influenced along the way.

00:43:49

Yes, we do see some kidney affectation and other symptoms during long COVID illness, but I think those can be explained by the microvascular coagulation.

00:44:01

An injury that caused that collateral damage, but a lot of it is related to exactly what we expect from spike protein.

00:44:09

We've also seen that there's a great similarity in those symptoms seen in long COVID.

00:44:15

With the reports that we now getting through diverse system on the types of injuries that are being presented through vaccinations as much as we cannot comment on the count of those injuries.

00:44:29

But the pathologic spread of those injuries matches exactly what we would have expected from a pathologic.

00:44:35

Protein like spike.

00:44:37

So Spike protein, I think, should form the center of what we look at.

00:44:42

I've termed it spike protein illness so that we draw attention to what's going on spike protein illnesses.

00:44:48

What occurs on?

00:44:49

The 8th day.

00:44:50

It also occurs postvaccination.

00:44:53

It's also what's keeping long COVID going.

00:44:57

And so I think by definition we need to understand the short and long end of spike protein illness, and that's what's going to give us insight into where we're going from here.

00:45:06

And so Spike protein is a very, very important protein.

00:45:11

I think with all the conspiracy theories going on around the world, I think we need to understand that we are dealing with something very toxic.

00:45:21

Uh, nature could never conspire to put together such an array of pathogenic proteins into a single protein and stick it onto the spike of a virus and make it infect human beings.

00:45:38

So I'm of the opinion that this is an engineered protein, a lab engineered protein.

00:45:45

That's the only thing that makes sense 'cause I can't see how mutation over centuries would have produced this and it would have gone unnoticed and suddenly appeared with no ancestry to it and we would have plotted a course along.

00:46:00

Along our timeline, so Spike protein is definitely engineered.

00:46:04

That throws a lot of light into what is actually happening around us.

00:46:09

If this is a toxic.

00:46:12

Then it's one of the most elaborate, well engineered, well thought of toxins ever produced by man.

00:46:19

And our understanding of it will keep us safe.

00:46:22

So going back to you made an observation where you have compared the reactions after the vaccine to this 8th day observation.

00:46:32

Could you talk about that?

00:46:34

Yes, I am now in South Africa starting to see a vaccine side effects, breakthrough infections.

00:46:41

All that.

00:46:41

Kind of thing.

00:46:42

So I need to very early on I needed to make sure I understood the vaccination status of my patients.

00:46:51

And so that I could make sense of what was going on with this with this vaccine itself, and what I found early on, I was getting a subset of patients 7 to 10 days after vaccination with the M RNA vaccines that we're starting with symptoms and we're testing positive for covert.

00:47:10

And there seemed to be a large subset of these patients, presenting to me 7 to 10 days after their vaccinations.

00:47:17

Now that would, that's that's very unusual, but too many to be coincidental.

00:47:23

So I started looking at that subset.

00:47:25

It had occurred at a time where the Delta variant was prevalent, and of course around the world.

00:47:30

People were terrified of the Delta variant, seeing that people were crashing into hospital very early on.

00:47:37

Uh, I had friends in India, used my protocol and I've kept in close contact with them and they had the same happen when they had the delta variant there they found that by the 3rd or 4th day there was a small percentage of people D saturation and any ending up on a ventilator, but that never occurred here in in, in, my modality, and in looking at my patients.

00:47:57

It always occurred after the 8th day.

00:47:59

So I looked at that and I thought why would someone suddenly desaturate?

00:48:02

On the 4th day.

00:48:04

And so I advise them to please make note of the vaccination status of these patients so that we could understand whether the vaccine was playing a role in this.

00:48:13

Not just blame it on Delta variant 'cause I was expecting as this pandemic evolved we would get more contagious variants but less infectious variants and so it will fizzle out into an endemic.

00:48:24

Form of the virus, and that's usually what happens.

00:48:27

So when we started seeing cases in South Africa, I decided to take the opportunity.

00:48:34

To understand why patients were deteriorating so suddenly earlier on, prior to that eighth day.

00:48:43

Now I was of the opinion in those subset of patients that we were not dealing with code.

00:48:49

What was happening here and this was my theory was that patients were getting the inject.

00:48:56

They were starting to develop spike protein by the 7th to 10th day.

00:49:02

The spike protein triggered the allergic reaction and that presented exactly like COVID illness would on the eighth day.

00:49:12

And so these patients that were coming to us were not on their first day of the illness.

00:49:16

They had avoided the entire viral phase of the illness, and we're presenting to me directly with spike protein illness.

00:49:24

And if I did not treat that spike, protein illness timelessly and waited another eight days to see what would happen, those that were severely allergic would desaturate within three or four days, so that patient that was landing in hospital breathless on the 4th day.

00:49:41

He was not actually on his foot.

00:49:44

Day he was actually on his 12th day in the natural progression of illness because he had skipped the viral phase completely.

00:49:51

Uh, in this vaccination the vaccine was the vector.

00:49:56

It was not the coronavirus, so the exposures to spike protein was through a vaccination, and so in that subset of patients I decided that anyone that came to me within 7 to 10 days or even I marked it up to three weeks.

00:50:12

Postvaccination with COVID illness.

00:50:16

Would require the biomarkers to be done.

00:50:19

I would usually do biomarkers post 8th day to track the course of the illness and to look at recovery so patients that came in on the 7th, 8th, 10th day after a vaccine showing signs of COVID I would draw their blood samples and send it off.

00:50:35

And if it was in a reaction to spike protein, I would see elevation in those biomarkers, unlike, we'd see in a viral infection in the first seven days.

00:50:43

The biomarkers tend to be relatively reasonable, and there's no real spike in them.

00:50:49

And so those patients that had elevated biomarkers on the first or second or third day of.

00:50:53

Illness, I knew that was spike protein and so I deferred directly to treating them as I would a patient on the 8th.

00:51:00

Day as well.

00:51:02

These patients were making spike protein in their body for the first seven or eight days, and so they had this gradual exposure to spike protein.

00:51:10

These vaccinated patients, and so I expected.

00:51:14

That they would develop immunoglobulin E as well, 'cause they had seven days of exposure already to this protein may be in minimal doses.

00:51:21

So I started testing patients that came seven to 10 days after vaccinations for Ige levels.

00:51:28

And yes, I had those that were mildly elevated, but I found some very severely elevated levels. Now IG is usually below 100.

00:51:38

I've had patients come to me on the 2nd day of illness with values of 4000. I've seen that also in long COVID patients with elevated Ige levels in the four and 5000.

00:51:49

And of course, the Ige tended to track the recovery as well as we got them recovered.

00:51:54

The IG level started to decrease.

00:51:57

Now in those patients.

00:51:59

That came to me postvaccination a lot of them had reactions and spontaneously recovered with symptomatic treatment.

00:52:06

And that's the reason people say that out when you get covert, it prevents severe illness or death if you vaccinate it, but they wear that subset of patients who I was concerned would suddenly crash.

00:52:18

On the 4th or 5th day and I needed to know who that subset actually were, and I found that an early estimation of IgE in those patients managed to show me the risk.

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So those patients with markedly elevated IgE levels were more prone.

00:52:37

Two allergy from this and we're more likely to have a severe allergic reaction.

00:52:41

Or have this allergic reaction spiral out of control and so I use that as a measure of keeping my eye on those patients post vaccination that had risk of suddenly deteriorating.

00:52:54

And so I found that that proved a very important.

00:52:58

As to the severity of reaction post vaccination, so yes, we're dealing with spike protein illness.

00:53:04

Those patients that presented more than a month after vaccination I could reasonably assume that they were breakthrough infections they had a month to develop immunity.

00:53:15

They never had the initial reaction to spike.

00:53:17

Protein and so any covert infection that they presented with was a true natural infection that had bypassed their immune response.

00:53:25

So clearly I was seeing that the vaccine wasn't confirming any immunity to those patients, and they were still having breakthrough infections.

00:53:33

Strangely enough, I had a lot of patients who took the vaccine in a month or two later presented with COVID.

00:53:40

Yet for the last year and a half were out and about in public, some isolating some not so.

00:53:46

It seems strange that a month and a half hour or two after vaccination you suddenly developed kovid with a milder variant.

00:53:53

But you were exposed to all the others that nothing happened, so I've always had it to the back of my mind that this vaccine might be suppressing immunity.

00:54:00

And making you more prone to picking.

00:54:02

Up the illness.

00:54:03

And of course, if you looked at the trends around the world, you would find that there was always a spike in cases following mass vaccination campaigns and so did that mass vaccination actually do two things.

00:54:15

One triggered a host of Spike protein illness that was misdiagnosed as COVID illness.

00:54:20

And two suppress people immunities and made them more prone to picking up the virus in the 1st place, and so that created the spikes in cases that we saw post post mass mass vaccination campaigns.

00:54:32

So I think look with those patients that presented with true breakthrough infections.

00:54:37

The timeline remained the same and they had the 8 days.

00:54:40

A viral infection.

00:54:41

They did deteriorate on the eighth day, and so the treatment modality remained pretty much the same.

00:54:49

I'm just thinking about this and what that might mean for the boosters that come up with each subsequent sort of booster dose that you get.

00:54:58

Is it going to be, well, we know that they say that the second dose gives you, you know, you get more of a, uh, you can put more sake.

00:55:07

Is that going to?

00:55:08

New perspective gonna keep going.

00:55:10

Yeah, I think it's a.

00:55:15

The full dose of penicillin.

00:55:17

The more you take, the more alarming.

00:55:20

And I think that's that's what's going to happen now if I had to just put into perspective how I see these vaccines working.

00:55:27

I haven't yet seen an immunological benefit from the vaccine itself.

00:55:32

It hasn't stopped infection.

00:55:33

It hasn't stopped transmission quite clearly, so there is now this.

00:55:39

Uh, advertising to say that it prevents severe.

00:55:43

Illness and death.

00:55:45

I think that's ludicrous to think that it's not a vaccine job to be preventing severe illness and death, and that is the job of therapeutic intervention, and calling it a vaccine when you taught it as a therapy.

00:56:01

Or touch the therapeutic benefit allows you to play in two different games at the same time.

00:56:08

You avoid the close scrutiny of therapeutics and and are able to take advantage of the latitudes of vaccination from a liability perspective and from a research.

00:56:22

So therapeutics go through fast, stricter, stringent measures before they are authorized.

00:56:28

Vaccines tend to have a broader latitude to them, so you call yourself a vaccine, but you only have a therapeutic benefit, and we're looking at therapeutic benefits.

00:56:36

My intervention does the same.

00:56:39

It prevents the VA illness or death, but I do not.

00:56:42

Expose the entire planet to the side effects of my treatment.

00:56:46

I I restricted to those that are ill and I can justify it in those that are ill.

00:56:51

The vaccine claims the same, but we want to give everyone in the vaccine.

00:56:58

For a therapeutic benefit.

00:57:00

I I think as well with the vaccine, we need to understand how it gives us that therapeutic benefit.

00:57:06

It is not through any immune mediated resistance to a virus or antibodies generated towards virus.

00:57:14

It is more to desensitisation to spike protein.

00:57:21

Those that are allergic to spike protein when they're exposed to spike protein through the vaccine itself will develop a measure of tolerance.

00:57:30

And through that measure of tolerance, when they get the infection itself and have exposure to spike protein on the eighth day, they won't react that severely.

00:57:39

'cause they partly tolerant and so it will decrease the severity of illness and mortality.

00:57:44

But that tolerance will slowly wane once the exposure to spike protein has passed.

00:57:50

And so, uh, booster will become necessary so the vaccines are not stimulating an appropriate immune response to arrive.

00:57:59

They are giving us a measure of tolerance.

00:58:02

So what we actually bring to the population is desensitizing them to an allergen.

00:58:09

Now we've done that many times.

00:58:11

It's it's a common known procedure in medical practice.

00:58:15

Those that have severe allergies to certain specific allergens.

00:58:19

Can be desensitized.

00:58:21

And so repeated exposure to higher and higher doses would trigger less and less reaction on re exposure to that allergen.

00:58:28

But it makes me wonder why we're trying to desensitize people to this allergen spike protein, because the only way to be exposed to spike protein is either through a virus or throw a vaccine.

00:58:40

So when you get the first infection.

00:58:42

With the virus you expose the spike protein.

00:58:45

You will develop a natural immunity to the virus, the vector, and so by being immune to the vector.

00:58:54

You will never be exposed to spike protein again.

00:58:58

And so why do we need to develop tolerance?

00:59:02

Why do we need to look at vaccines that use by protein?

00:59:07

We survived the allergic reaction we immune to the vector and we'll never be exposed again.

00:59:15

This is not an allergen that is naturally occurring in our environment that would cause re exposure.

00:59:22

However, if you've got a family member that's taken the vaccine and he's walking around covered in peanut oil, and you're allergic to peanuts, you're going to keep being exposed to spike protein.

00:59:32

And we're going to have problems there.

00:59:33

I see there was a question on shedding.

00:59:36

Yeah, I've seen that happen.

00:59:38

I've had people that took the vaccine and had other family members.

00:59:43

Infected or let's say.

00:59:46

Have an allergic response to spike protein.

00:59:50

I sometimes need to point these things out to change the direction we're paying it.

00:59:54

I made a comment once that these patients that come on the seven to 10 day post vaccination.

00:59:59

I need a way to test to see whether they are actually having spike protein illness.

01:00:07

And not a viral infection.

01:00:08

And remember, the PCR test is a very insensitive test, and so it would test positive just for spike protein and so here these people were showing positive.

01:00:18

And so I threatened that I was going to get myself.

01:00:21

A set of.

01:00:22

Swabs and these patients that came in I was going to swap them in their nose and their armpit.

01:00:28

And if the sobbing, their arm could turned out positive.

01:00:30

It wasn't a viral infection 'cause you don't shed viral particles through your armpit, but you'll share spike protein through your sweat, and two days later.

01:00:38

The FDA decided that the PCR test wasn't the way to go, and it shouldn't be done on asymptomatic patients and so.

01:00:44

I think they.

01:00:45

Realized that we're going to find more than we wear that they intended us to find.

01:00:51

Oh my God.

01:00:52

So yes, we do shared the problem is whether we shared messenger RNA.

01:00:57

From the vaccines, spike protein is a transient protein and I think we can all stop vaccinating and we won't be exposed to it anymore and we can deal with the consequences of those that were exposed.

01:01:10

However, if you're shedding M RNA, then that's that makes this a transmittable vaccine, and even those that are on vaccinated.

01:01:18

At risk of being vaccinated against our will and against our knowledge.

01:01:24

Do you have any thoughts on like the duration of how long somebody might be able to transmit spike after they've been vaccinated?

01:01:34

Look, the transmission of spike would be, uh, would be determined by other people around you getting unwell.

01:01:41

And of course that only if they're allergic to spike protein.

01:01:44

So it's a very difficult thing to gauge, but I think that spike protein would last in the body for about four to six months after vaccination.

01:01:53

Simply, I draw that inference from the fact that your tolerance to spike protein seems to Wayne by four to six months after vaccination.

01:02:02

And if you still had spike protein, you'd maintain a degree of tolerance to severe illness or death.

01:02:09

And seeing that four to six months after the vaccination, you are again prone to severe illness or death.

01:02:14

It tells me that you know more exposed to spike protein through the vaccine itself.

01:02:18

And so I think four to six months would be the timeframe to look at exposure to spike protein.

01:02:23

That's really interesting, thank you.

01:02:24

Through residential

01:02:26

Your thoughts on giving this to children?

01:02:30

I actually have strong opinions about giving it to adults in the 1st.

01:02:34

Place children are absolutely nonsensical.

01:02:38

I think to put perspective into what this vaccine is actually doing and the public health interventions that we've allowed so far.

01:02:46

There they are nonsensical.

01:02:49

Two things that we we followed from from.

01:02:52

Of course, the people that seem to know what to do.

01:02:58

The first public health measure that was introduced was isolations and lockdowns, track and trace find the virus isolated.

01:03:05

Now to do that.

01:03:08

We had to lock down societies.

01:03:10

We had to isolate people we had to trace contacts.

01:03:13

All that kind of thing.

01:03:15

Now I found that unusual in that in all of human history we were never able to be.

01:03:21

We were never able to control an airborne respiratory virus through isolation lockdown tracing measures.

01:03:29

It was never possible, but suddenly now we were choosing that as the mainstay of our public health intervention measures, and I knew from the start that was destined to fail.

01:03:39

Now to make that effective, your aim was to find the virus, isolate the virus and prevent it spreading.

01:03:46

That was the basis of all the measures.

01:03:51

The isolation, the tracking and tracing everything was meant to find the virus isolated before it spits.

01:04:00

Now, to do that, there's two things that you need.

01:04:04

You need speed because it spreads when you need to catch it before it spreads.

01:04:09

And of course you need good eye.

01:04:10

Sight to find it.

01:04:12

So you can't be searching around in the dark.

01:04:15

But we were given a PCR test that was partly blind.

01:04:19

It never did what it's supposed to do, so use an analogy where you're trying to isolate 2 grains of black rice in a bowl of white rice, and it's going to spread, so you need speed and you need the ability to find those two black grains of rice and remove them very quickly.

01:04:35

But we were given a faulty PCR test to do that, and so their faulty PCR test is like being partly blind.

01:04:42

Trying to find that rice, you're never going to achieve your goal, and so I think everything conspired to ensure that the public health measures failed.

01:04:51

The the vaccination program was the 2nd means to get us to back to supposedly normal and of course in all of human history.

01:05:01

We have never been able to proto.

01:05:04

To make a vaccine against an MRU virus, we tried this every year with the flu.

01:05:11

Viruses and we've never had great efficacy in doing.

01:05:14

That this is an RNA virus that is highly mutagenic, even more mutagenic than the other commonly known RNA viruses.

01:05:23

So we were destined to be chasing our tails.

01:05:27

By the time we got an effective vaccine against one variant, the variant would change, and by the time we understood the change and manufactured.

01:05:35

New vaccine against that variant could have changed again, and that's what we've seen.

01:05:39

For decades now, with the flu vaccinations, we use the common strain in the northern hemisphere to create a vaccine and vaccinate the southern hemisphere.

01:05:48

Uh, hopefully they would get the same strain and then we use the Communist reign in the southern hemisphere during flu season to make a vaccine for the northern hemisphere.

01:05:57

And so we've had about 20 or 30% success, so the vaccinations were destined to fail. I was. I was mortified when I heard that they were going to use vaccinations.

01:06:08

To try and achieve herd immunity.

01:06:11

The Mets could never add up. You need a vaccine that is close to 100% effective to get to herd immunity.

01:06:19

Just to put context to that, if you had 100% effective vaccine and you vaccinated 70% of your population, you'd have 70% herd immunity.

01:06:29

If you had a 50% effective backs.

01:06:32

And you very vaccinated 100% of the population. He had 50% herd immunity. That's all you could get to now.

01:06:38

The vaccine that's only 20 or 30% effective, we should have abandoned herd immunity along time ago, but I think the narrative around herd immunity was simply to encourage everyone to take the vaccine.

01:06:50

Yes, we need.

01:06:51

Everyone to take it, but when we realized that it wasn't as effective as initially thought to be, that plan should have been abandoned from the stops.

01:06:59

As soon as we realized the lack of efficacy, herd immunity became a non starter.

01:07:03

And so I think that the vaccination program was destined to fail, and it's strange that we have all these different means at our disposal to manage a pandemic.

01:07:14

But we chose the two that were destined to fail, and we suppressed the rest that might have worked.

01:07:20

Yeah, it's very.

01:07:23

It's pretty much over one.

01:07:27

Thank you so much for all of us everybody in the comments is funding it.

01:07:31

Totally fascinating.

01:07:33

Uhm, well, lastly, before we go have you has anybody in the world in terms of governments or.

01:07:41

Authorities around the world being able to take your advice.

01:07:45

Have you been able to give guidance?

01:07:49

Early I think look, there's a lot of controversy surrounding what I do.

01:07:54

It started when I attempted to publish my article.

01:07:57

It was never meant for publication.

01:07:59

I always wanted to share it with doctors and educate public.

01:08:02

I didn't see the reason to ask.

01:08:03

Permission to save lives.

01:08:05

And so the governing body is traded in play a part.

01:08:07

In my work itself and I passed it on to a peer, a colleague of mine that I've grown up with, the cardiologist that was at the time working in Italy and asked for his opinion.

01:08:18

Yeah, before I even considered public publishing this article and he asked me.

01:08:23

He said, look I'm I'm amazed at what you found.

01:08:26

But there's two lines in this article I'd.

01:08:28

Like you to remove.

01:08:29

And I said which two lines?

01:08:30

And he said the one that says that if early treatment could negate all the mortality and morbidity in this.

01:08:38

It would make the need for mass vaccination wholly unnecessary, so please remove that and I said no, I'm not.

01:08:44

We need the full perspective and when my article was published it became the most controversial article published in that particular journal simply because of those two lines, and I couldn't understand why bringing perspective would cause such controversy.

01:08:58

After all, the patient in front of me is a representation of humanity and I'll do everything to save his life.

01:09:04

I don't care what the global bodies are doing if it's not influencing the way I treat the patient in front of me makes no difference, and so my aim from that point on was to educate Doc.

01:09:16

This and to educate the population I needed to take away the fear, and I think that the education takes away that fear.

01:09:23

The understanding that this is treatable, and so I I went down that road working with doctor associations around the globe, training doctors in different parts of the world, educating public.

01:09:36

Town hall meetings.

01:09:37

Those kind of.

01:09:38

Things, and I think that's where the work started.

01:09:41

Yes, I've been approached by a myriad of different political figures, legal figures around the world, but of course they have their respective groups to deal with and so we have.

01:09:52

The agendas that are.

01:09:56

That are almost set in stone.

01:09:58

I'm not here to enlighten ignorance and the ignorance, especially if it's an agenda.

01:10:02

OK.

01:10:04

Ignorance will never change and so I need to change where I can change, and I think that's what doctors and with patients.

01:10:11

I think with the doctors as well.

01:10:14

A lot of them are bound by hospital protocols.

01:10:17

And so that is, uh, that has made it difficult to actually have this outpatient kind of protocol.

01:10:22

Follow on.

01:10:23

With hospital treatment I've been pushed into a situation where I'm forced to do ICU treatment on an outpatient basis, 'cause patients refuse, no matter how critically ill they are to be hospitalized and.

01:10:37

Thank God I've I've.

01:10:37

I've actually had the success I've had, but I would have liked to have the peers around.

01:10:44

Me being able to provide the support I require from the hospitalization and tertiary setups we could have understood this illness a lot more quickly in the 1st and 2nd wave there wasn't a single facility around me willing to do an X ray on an outpatient or willing to do a blood test on an outpatient.

01:11:04

You needed to have them hospitalized and they refused to go to hospital.

01:11:08

So the 1st and 2nd wave and a lot of the work that I've done had to be done with clinical observation.

01:11:15

Making sure that patients recovered and that recovery would determine how I treat them.

01:11:20

It was only now in the third wave that labs and the facilities for investigation opened up and I started to recognize the trends in biomarkers and the trends in X rays and all the others that all the other information that we needed.

01:11:36

To understand more clearly what's going.

01:11:38

So yes, I've had here in South Africa we had quite a few amps contact me.

01:11:43

We have a movement set up to push back.

01:11:46

I have a lot of legal experts around the world in contact with me.

01:11:50

I had I had an interview with Craig Kelly in Australia.

01:11:55

I've had quite a few people around the globe.

01:11:57

Interested in this, but I think there's a bigger agenda and all of us are facing a lot of difficulty there.

01:12:04

If I have to look at how we're going to turn the ship around, it's for every individual to be educated about what's going on, and until we stop poisoning the planet.

01:12:15

We ain't going to turn this around, and I think it's for people to understand that spike protein is toxic.

01:12:19

We have a myriad of different ways to vaccinate.

01:12:22

Why did we choose the most deadly?

01:12:25

We have live attenuated vaccines that could do the trick.

01:12:29

They are the traditional way of making vaccines and why haven't we done?

01:12:33

That there's a lot of nonsense that we see.

01:12:36

I asked this to a researcher just the other day.

01:12:39

I said we've developed a vaccine with messenger RNA, and if you look at what this vaccine is meant to do.

01:12:45

The messenger RNA must get into yourselves.

01:12:47

It must get those cells to make spike protein.

01:12:50

That spike protein must trigger an immune response in your.

01:12:53

Body that immune response must make antibodies and those antibodies, if neutralizing, would hold you in good state.

01:13:01

When you expose exposed to the virus.

01:13:04

Now the messenger RNA is new technology.

01:13:06

We don't know about its distribution.

01:13:08

We don't know about it's how long it will live in your body.

01:13:11

We don't know how much of spike protein it's going to make.

01:13:13

Its a lot of it will be dependent on the individual itself and so we have all these variables.

01:13:19

I asked a simple question why didn't we inject people with spike protein?

01:13:25

He could have triggered the same response you would have got antibodies to spike protein and those antibodies if neutralizing, but it prevented you getting Corona.

01:13:33

Why was it so contrived with messenger RNA?

01:13:36

Maybe the messenger RNA has a part to play in all this, and so we've got to be very cautious.

01:13:41

The science can be mind boggling.

01:13:45

And it can be confusing and I think we need to be.

01:13:48

We need to dumb it down and see the.

01:13:51

Logic in things.

01:13:52

The prevention of severe illness and death.

01:13:55

Which the vaccines claim is an individual benefit if it prevented infection and prevented transmission, it would have a group benefit.

01:14:05

And so you taking the vaccine would benefit me, but it clearly doesn't have that.

01:14:09

The prevention of severe illness and death is an individual benefit.

01:14:13

If you take the vaccine, you might not.

01:14:16

Get severely ill or die that has no benefit to me so it does not confer group benefits.

01:14:22

And if it does not confer a group benefit mass vaccination mandates make absolutely no sense.

01:14:30

And so until they prove to us a group benefit to the vaccine, we've been coerced into taking it.

01:14:39

Yes, here in New Zealand we're in this funny space we're.

01:14:42

I'm sure it's that way over there where you are to.

01:14:46

Where they will admit that it doesn't impact on transmission and infection.

01:14:50

But at the same time, they will also ask you to take it for your father or your community, or you know the vulnerable people around you like that.

01:14:59

They're asking you to hold these two beliefs.

01:15:01

At the same time, even though they're wildly opposing.

01:15:03

Yes, I think.

01:15:04

The I think the illogic we're all aware of the logic we're all aware of, the censorship, the lack of information.

01:15:13

The the the the collusion, the coercion.

01:15:17

I think it makes the way to make it make sense is to understand the bigger picture.

01:15:22

Why would they want the entire planet to be exposed to a toxic?

01:15:27

We know the vaccines don't work, but you still should take it.

01:15:31

We know that it has group benefit, but for the benefit of society you need to take it.

01:15:36

What is in that vaccine that is so important that we actually get the entire planet exposed to it?

01:15:43

If you look at historically the divisions in society have allowed people to be governed and ruled.

01:15:51

And so those at the top always wished to sow the seeds of division so that they keep us fighting with each other and not watching what they're actually doing now in over the past few decades, uh, humanity has overcome the boundaries that race, religion, and our physical boundaries have separated us into.

01:16:10

So of course we need something new to divide us.

01:16:14

And vaccination provides the ideal tool as long as it is marketed with the right narrative.

01:16:20

So this is something that doesn't need race or religion to be divisive.

01:16:24

It will divide us along family along family lines and so I think people need to wake up.

01:16:31

Need to understand that this makes.

01:16:33

No sense at all.

01:16:35

The vaccine doesn't give you blue blood.

01:16:37

So it makes no sense to be taking it and thinking that you are now in a better place.

01:16:43

Everyone is at the same risk.

01:16:46

I can't understand why we why we trying to be so divisive with this, but of course there's a bigger plan at play.

01:16:52

It's those of us that are unvaccinated.

01:16:54

There are lateral thinkers that will dig deeper and not follow the narrative are those that pose the greatest risk.

01:17:03

To people in government.

01:17:05

And so we're the ones that need to be ostracized and pushed to the fringes of society.

01:17:10

And I think that's the bigger picture.

01:17:12

Yeah, yeah.

01:17:13

Yes it does, and they they're trying to at the moment bring in the vaccine passport kind of system, where basically anyone that's not vaccinated is not going to have any fun this summer as basically, but what we've been told but.

01:17:26

We're quite a.

01:17:26

But that is well.

01:17:27

Team and make our own fun.

01:17:27

There yeah, yeah, that is that.

01:17:30

That is nonsensical as well.

01:17:32

What justifies?

01:17:34

A vaccine passport.

01:17:36

Uh, I've been pushing too.

01:17:39

If you wish to issue an immunity passport.

01:17:44

That's what tells you you say, and that's what tells the rest of society that you won't get infected.

01:17:50

The way to immunity is twofold.

01:17:52

Uh, one through a natural infection or through vaccine induced immunity so it would be pretty simple to develop a cell test to look for long lasting broad based natural immunity and so we would issue an immunity passport to those who have immunity.

01:18:10

Whether it was arrived at.

01:18:12

Through natural infection or vaccine is irrelevant and that would be the pragmatic way to go through.

01:18:18

Go through doing this, I think.

01:18:20

However, developing a test to show immunity would show up the inefficiencies in the back.

01:18:26

A lot of people that were vaccinated won't qualify for an immunity passport as well.

01:18:31

With vaccination, there is no guarantee that when you vaccinated you would develop an appropriate immune response.

01:18:37

People that are immunocompromised and chemotherapy and all that kind of thing will not develop a response, but they qualify for a passport even though they are infectious.

01:18:46

And transmissible to this virus as the rest of us in society.

01:18:49

So I think the passport is just.

01:18:51

A divisive means.

01:18:53

To get society to to that point, immunity natural immunity has been proven to be robust, broad, long lasting people want to want me to ask me how long do you think the immunity lasts and I said, well, you only survive two years since you had the infection so well. People with the Spanish flu have survived 100 years and still had immunity.

01:19:13

So let's see how long you live in or give.

01:19:15

You that answer but.

01:19:18

The vaccine is trying to imitate natural immunity.

01:19:25

So I can't see how vaccine immunity can be superior to natural immunity if vaccine immunity is trying to imitate natural, I mean an Elvis impersonator or impostor can never be as good as Elvis.

01:19:40

And so yeah.

01:19:41

Impostor, I think, is the right to it when it comes to vaccinations.

01:19:46

Now I've seen.

01:19:47

A few people asking in the comments, so I'll bring it up and people are asking about norwex.

01:19:51

I think here in New Zealand with we've mostly got fired. I think they've they've approached some of the other ones, but they're really not available yet, and some people will be holding out for the snow of XI. Mean it's my understanding it's still utilizing this spike, so this what would.

01:20:07

Just thought to be on there.

01:20:08

I would look at two things when it comes to vaccination and that's if we required to be vaccinated.

01:20:15

The vaccine should be either a heat killed or live attenuated whole virus vaccine.

01:20:21

Those two kinds of vaccines have been developed in the past.

01:20:26

We have the technology to do that.

01:20:28

They would be safe simply because we don't have the messenger RNA or any other new technologies to deal with.

01:20:35

Once we have those kind of vaccines developed, they would be the ideal vaccines that would stimulate a broad, diverse, long lasting immune response.

01:20:44

'cause you'd get antibodies formed to all bits and pieces of the virus itself, right?

01:20:50

So any vaccine that uses spike only.

01:20:53

I would avoid at all cost.

01:20:55

Secondly, we found that the injectable vaccines which we're using at the moment.

01:21:00

And trigger humoral response.

01:21:02

But we want mucosal immunity because the 1st place you fight this virus is in your nose.

01:21:06

So I think we need to tend towards the development of nasal vaccines when it comes to respiratory viruses and they will give us far better protection.

01:21:15

But remember this is if required.

01:21:18

Natural immunity is still the best.

01:21:21

You get the infection.

01:21:23

You get treated, you develop robust natural immunity, and then you throw away your mask and you go back into natural into society itself.

01:21:31

At this point in time, irrespective of the public health intervention measures, the people that have gone through the distress.

01:21:39

Of fighting COVID and recovering from it are the safest people on this planet right now and we should not be discriminating against him.

01:21:51

So true, thank you.

01:21:54

Well, that's was an amazing amazing hour and a half.

01:21:57

Thank you so much for coming on the show.

01:22:00

I think that this is going to be one of those interviews that gets widely distributed around our country and it's going to really bumped.

01:22:07

I'm hopeful I, I think the sharing of such education is vitally important.

01:22:08

It this way.

01:22:13

Uh, it's worth nothing in my hands and I can't do this alone.

01:22:17

So if people understand, I'm sure we can put all hands on deck.

01:22:21

And I think gain our freedom back.

01:22:24

We were told that jail is the safest place for us.

01:22:26

We all gladly gave up our freedoms for our protection today if we went out.

01:22:31

We need to take a vaccine.

01:22:33

We were herded like sheep, into a crown and now the only way out is through the dip.

01:22:37

So humanity needs to open its eyes and get out of this stream.

01:22:41

And I think people rising up, which I'm seeing around the world.

01:22:45

Uh is what's going to change the narrative.

01:22:49

Indeed, and thank you so much because it's with this kind of education that we are able to.

01:22:56

They boasted in our confidence as to what the choices are that we we have ahead of us.

01:23:01

So thank you.

01:23:03

Thank you so much and thank you everybody for being here tonight and we'll see you at the.

01:23:08

Next, and the next talk.

01:23:11

Thank you very much, OK?

01:23:11

Thank you, thank you.